STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING _____ B. WING _____	C 01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00083946 and Complaint IN00084536. Complaint IN00083946 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00084536 - Substantiated. Federal/state deficiencies related to the allegations are cited at F 312 and F 364. Unrelated deficiencies cited. Survey dates: January 10, 11, 12, 2011 Facility number: 000195 Provider number: 155298 AIM number: 100267690 Survey team: Julie White RN Census bed type: SNF/NF: 85 Total: 85 Census payor type: Medicare: 8 Medicaid: 63 Other: 14 Total: 85 Sample: 5 Supplemental sample: 2 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review 1/19/11 by Suzanne Williams, RN	F 000	RECEIVED FEB - 7 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH ENTERED FEB 9 2011	

approved 02-11-11 Rhonda R

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

See attached fax sheet for date

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00083946 and Complaint IN00084536.

Complaint IN00083946 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00084536 - Substantiated. Federal/state deficiencies related to the allegations are cited at F 312 and F 364.

Unrelated deficiencies cited.

Survey dates: January 10, 11, 12, 2011

Facility number: 000195
Provider number: 155298
AIM number: 100267690

Survey team:
Julie White RN

Census bed type:
SNF/NF: 85
Total: 85

Census payor type:
Medicare: 8
Medicaid: 63
Other: 14
Total: 85

Sample: 5
Supplemental sample: 2

These deficiencies also reflect state findings in accordance with 410 IAC 16.2.

Quality review 1/19/11 by Suzanne Williams, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Melissa DeHart 02.03.11

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F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 2 residents in a supplemental sample of 2 received two showers a week. (Residents # G, # H) Findings include: 1. Interview with Resident # G on 1/11/11 at 1:40 p.m., indicated he often does not receive his two showers a week. Resident # G indicated he is usually the last resident showered on evening shift and staff often tell him they do not have time to give him his shower. Review of Resident # G's January 2011 "ADL (activities of daily living) Worksheet" on 1/11/11 at 3:00 p.m., indicated Resident # G received a shower on 1/10/11. No other showers were documented as given from 1/1/11 to 1/9/11. Review of Resident # G's clinical record on 1/12/11 at 6:15 a.m., indicated Resident # G's diagnoses included, but were not limited to, Parkinson's, depression and back pain. No documentation of shower refusals were found documented in Resident # G's nurse's notes or behavior log. The most recent cognitive assessment, dated 11/24/10, indicated Resident	F 312	F-Tag F-312 Element # 1 What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? It is the policy of this facility to see that ALL Residents receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. Resident's "G" and "H" currently receive their two showers per week on days and at times of their preference. These showers are documented. Element #2 How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. A facility wide audit was conducted to see that all Residents are scheduled for two showers weekly unless there is a significant medical reason and doctor's order to contraindicate this. All Residents who are interviewable have been consulted as to a preferred day and time. This is documented. As Residents are admitted they will be asked their preferred days and times for their showers. Their requests will be honored.	

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F 312	Continued From page 2 # G was "...alert and oriented to person, place, and time...Cooperative with care. Decision-making consistent and reasonable...." 2. Interview with Resident # H on 1/11/11 at 2:50 p.m. indicated she just received one (1) shower last week due to the "...aide had to leave early..." Resident # H indicated her showers are on evenings and she usually receives her showers on Wednesdays and late on Fridays or early on Saturday. Review of Resident # H's January 2011 "ADL Worksheet" on 1/11/11 at 3:00 p.m., indicated Resident # H received a shower on 1/5/11. No showers were documented on 1/6/11 through 1/9/11. Review of Resident # H's clinical record on 1/12/11 at 6:55 a.m., indicated Resident # H's diagnoses included, but were not limited to, Parkinson's, dementia, diabetes and cardiac arrythmia with a pacemaker. No documentation of shower refusals were found documented in Resident # H's nurse's notes or behavior log for January 2011. The most recent cognitive assessment, dated 12/10/10, indicated Resident # H was "...alert and oriented to person, place, and time. Speech clear; hearing adequate...Pleasant and cooperative with care. Decision-making consistent and reasonable...." This federal tag relates to complaint IN00084536. 3.1-38(a)(2)(A)	F 312	The DON or designee will interview 10 Residents a day on 3 days per week, various shifts. To see that they are receiving showers as per their plan of care and to their satisfaction. Any concerns will be addressed upon discovery. These shower audits will continue until 4 consecutive weeks of "zero" negative findings are realized. Also, ADON (Assistant Director of Nursing) will monitor shower documentation at least five days weekly for accuracy on going. Any concerns will be addressed immediately with the staff involved. Element # 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? At the all staff in-service held on 02/08/11 the necessity to respect Residents' Rights and their choices being honored will be reviewed. Shower schedules will be discussed as well. Documentation of showers will be reviewed and those responsible for giving ADL care and seeing that it is well documented will be reiterated. Any staff who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive .	F 328		

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F 328	Continued From page 3 proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure an emergency (spare) tracheostomy/trach tube was at the bedside/readily accessible for 1 of 1 resident (Resident # C) currently in the facility with a tracheostomy. The facility further failed to ensure 1 resident (Resident # F) with a tracheostomy had the correct size and make trach tube in place for 1 of 2 residents reviewed with a tracheostomy in a sample of 5 residents. Findings include: 1. Review of the clinical record of Resident # C on 1/10/11 at 2:00 p.m., indicated the following: Resident # C's diagnoses included, but were not limited to, aphasia, tracheostomy with excessive secretions, history of CVA (cerebral vascular accident) and asthma. Physician's orders signed by the physician on 12/27/10, indicated "...Bivona 7.0 uncuffed trach - change monthly...." Resident # C's care plan for "At risk for impaired	F 328	Element #4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place 02/11/11. At the monthly Quality Assurance meeting the results of the shower audits by the DON and ADON will be reviewed. Any patterns will be addressed immediately upon discovery. If necessary, an action plan will be written by the Administrator and the Quality Assurance nurse to be monitored weekly by the Administrator until resolution is achieved. 02/11/11 F-Tag F-328 Element #1 What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? It is the policy of this facility to see that any Resident who has a special need such as a tracheostomy receives all proper, appropriate and necessary care. Currently, Residents "C" and "F" have emergency spare trach kits at their bedsides. There is at least one additional trach in the supply room at all times of the proper sizes and types for these residents. The orders for trach size, type and care have been	

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F 328	Continued From page 4 air exchange & (and) resp (respiratory) infection R/T (related to) tracheostomy" indicated, "...approaches...observe for sx (signs/symptoms) of hypoxia...trach care Q (every) shift & (and) PRN (as needed)...." On 1/11/11 at 11:32 a.m. RN # 1 was observed to look around Resident # C's room for a spare/emergency tracheostomy at his bedside. No spare tracheostomy was found. RN # 1 then called LPN # 2 to the room who looked in Resident # C's 9 (nine) drawers, bedside table and shelves. LPN # 2 indicated staff must have forgotten to replace his spare trach the last time it was changed. LPN # 2 left the room and returned with a Bivona, uncuffed 7.0 tracheostomy tube at 11:37 a.m.. On 1/11/11 at 11:37 a.m., LPN # 2 indicated she was unable to find a spare tracheostomy tube on the floor and obtained the Bivona tracheostomy tube downstairs in the facility's supply room. LPN # 2 further indicated she often cares for Resident # C three days a week and Resident # C's spare tracheostomy tube is usually kept in the drawer with his suction supplies. The facility's main supply room was observed on 1/11/11 from 12:45 p.m. to 1:10 p.m.. One additional Bivona 7.0 tracheostomy tube was observed in the supply room. LPN # 3 indicated the facility was in the process of ordering additional tracheostomy tubes for Resident # C. LPN # 3 indicated not all staff have access to the coded/locked supply room. 2. During the initial tour of the facility with LPN # 6 on 1/10/11 from 11:15 a.m. to 11:40 a.m., Resident # F was identified as non-compliant with	F 328	clarified for both of these Residents and are documented and in place. Their care plans and associated documents such as med and treatment sheets have also been updated. Care Plans include size and type of trach and care to be administered. Note: Should the Resident need to be sent out of the facility a spare emergency trach of appropriate size and type will be sent with them. Care is being delivered (including suctioning) as appropriate and necessary for Resident's comfort and safety. Element #2 How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? A facility wide audit was done to be sure all Residents who have tracheostomies have the correct size and type in place. Further, all associated documentation was reviewed including but not limited to orders, care, med sheets, treatment sheets, care plans and any follow-up visits. The DON or designee will monitor all trach Residents at least 2 times weekly to see that all orders are accurate timely and complete. Also, all documentation will be reviewed to see that all planned interventions are being carried out. Any concerns will	

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F 328	Continued From page 5 suctioning of her tracheostomy and currently hospitalized. Review of the clinical record of Resident # F on 1/10/11 at 5:00 p.m., indicated the following: Resident # F's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), sleep apnea, and history of respiratory failure. An ENT (ear, nose and throat) physician dictation, dated 9/20/10, indicated Resident # F "...underwent tracheostomy placement...for respiratory failure, untreated sleep apnea,...She had a skin line tracheostomy and had a fenestrated 6 (six) Shiley trach tube in place but has a nonfenestrated inner cannula...If one were to cap this trach to check for the ability to tolerate breathing without the trach, I would have a fenestrated inner cannula in place or simply cap the fenestrated trach without having a nonfenestrated inner cannula in place. I would advise against doing so...She is not functioning well yet from my understanding and has copious secretions that she cannot handle well and is not able to communicate well with us...." A physician's order, dated 10/25/10, indicated "...Please re-eval (sic) endotracheal (sic) tube... (increased) coughing with trach change...." A physician's order, dated 10/27/10, indicated "Send to ...emergency...(increased) coughing eval + (and) tx (treat)." An undated physician's order, though numerically just under an order dated 11/1/10, indicated "clarification: cuffless, fenestrated # 6 Shiley trach."	F 328	be immediately addressed. This monitoring will be on-going. The ADON'S and/or charge nurses will monitor trach Residents and their care every day, delivering care as ordered and needed. Element # 3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? At an in-service for nurses held 01/25/11 and given by Respiratory Specialists, the care and treatment of tracheostomies was reviewed and discussed. This included physiology of the trach, O^2,care, cleaning, suctioning, changing, techniques for caring, orders, documentation, size, types and "what to look for" as far as signs of a possible complication. Any staff who failed to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate. Element #4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place 02/11/11.	

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F 328	Continued From page 6 An ENT physician note, dated 11/8/10, indicated "...I am not sure why (resident's name) was scheduled to see us today + neither is she. This was scheduled by someone @ (at) your facility, but nobody called me or sent me a note. Your team can certainly care for her trach... as per my dictated letter from 9/20/10. We recommended the # 6 Shiley but someone later changed her to a Portex tube...Please in the future, if you want our help c a trach: 1) contact us beforehand to discuss your questions/etc. 2) Send a spare tube, with obturator, so we can remove + change the tube...No treatment done today...." An ENT physician noted, dated 11/22/10, indicated "Pt's (patient's/resident's) trach may now be changed...the tract looks fine. No granulation tissue or obstructions...I am again disappointed that no physician has called us c any relevant history as to why pt (patient/resident) still needs the trach, despite my requesting this by phone c Nursing Mgr (manager) @ Cambridge Manor...I also requested that the pt (patient) be sent c a cuffless, fenestrated # 6 Shiley. She was instead sent 2 (two) cuffed tubes- 1 fenestrated, 1 non fenestrated. I did not place one of these cuffed tubes, but simply re-inserted her cuffless, non fenestrated Portex. I will leave all subsequent trach-related issues to you unless contacted otherwise by an MD (physician) who is familiar c her care." An emergency room note, dated 12/6/10, indicated "...Pt...initially refusing trach change. Pt. finally agreed to trach change. 6.0 Portex placed + 2nd (second) trach given for home. Pt to see (ENT specialist/ physician's name) in clinic ASAP (as soon as possible)...."	F 328	At the monthly Quality Assurance meetings the results of the weekly monitoring of trachs by the DON or designee will be identified. Note: Any concerns will be addressed upon discovery. If needed, an action plan will be written by the Administrator and Quality Assurance nurse. This plan will be monitored weekly by the Administrator until resolution is achieved. 02/11/11	

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F 328	Continued From page 7	F 328		

Nurse's notes, dated 12/23/10 a 6:00 p.m., indicated "...requesting to be suctioned today...mucus thick, brown tinged. Resident was able to cough c clear sputum...independent c (with) care...pleasant/cooperative...."

Nurse's notes, dated 12/25/10 at 4:30 a.m., indicated "Res refused all trach care and trach ("triangle shape"/change) despite several attempts, requested only to be suctioned...."

Nurse's notes, dated 1/6/11 at 7:00 p.m., indicated "Suction...per request. Thick blood tinged mucus...Able to have productive cough...."

Nurse's notes, dated 1/9/11 at 6:25 p.m., indicated "...notified...resident needed to be suctions, writer went back into Res (resident's) rm (room)...noted resident sitting on bed, coughing, ...started to suction resident...resident began to complain of S.O.B. (shortness of breath)...trach appears to be occluded, continues (sic) c suction (sic) c minimal secretions noted, Res continues to c/o (complain of) S.O.B., c (with) signs of hypoxia showing in resident's face...Resident cont (continued) to decline into respiratory distress and eventually lost consciousness, CPR (cardiopulmonary resuscitation) started...."

Nurse's notes, dated 1/9/11 at 6:45 p.m., indicated "911 was called c arrival of EMT, resident at this time revived but still shows respiratory distress. Resident transferred to ...ER (emergency room) for eval and tx (treatment)."

A physician history and physical, dated 1/9/11, indicated "...A...morbidly obese...female with respiratory failure, status post complete

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F 328	Continued From page 8 cardiopulmonary arrest secondary to respiratory arrest. I changed her tracheostomy tube out in the ER with the assistance of a respiratory therapist to a cuffed Portex # 6. This is the only tracheostomy tube we had available that would fit in her stoma, which is very tight. This change was done with moderate difficulty...She may need revision of her tracheostomy site secondary to the tightness of the stoma...." Resident # F had three care plans for "potential for ineffective breathing pattern" The three care plans did not indicate the size and make of trach tube Resident # F was to have to ensure effective breathing. During the daily conference, on 1/11/11 at 4:30 p.m., a request was made for clarification regarding the specific tracheostomy/trach tube Resident # F was to be using to maintain her airway. No clarification was given regarding why Resident # F presented to the ENT physician office on 11/22/10 with a Portex trach tube instead of a fenestrated # 6 Shiley trach tube. Interview with the director of nursing on 1/12/11 at 11:40 a.m. indicated Resident # F's ASAP ENT physician visit, requested during her visit to the ER on 12/6/10, was scheduled for 1/20/11. No further clarification regarding Resident # F's trach tube was provided prior to exiting the facility on 1/12/11 at 1:00 p.m..	F 328		
F 364 SS=B	3.1-47(a)(4) 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		

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F 364	Continued From page 9 food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to keep the doors of food carts closed to prevent potential heat loss during tray delivery service on 2 of 3 floors. This had the potential to affect 74 of 85 residents who receive food/meals from the facility's kitchen. The facility further failed to ensure 3 of 6 residents interviewed were served palatable food. (Residents # H, J, K) Findings include: A food cart with resident trays was observed to be delivered to the second floor on 1/11/11 at 11:50 a.m.. A second food cart arrived on 1/11/11 at 11:55 a.m. On 1/11/11 from 12:00 noon to 12:09 p.m., the food cart doors were observed to be left open while trays were passed to residents in the second floor west dining room. Interview with Resident # K on 1/11/11 at 12:11 p.m., indicated her food was hot today, but not always. Resident # K indicated the delivery of cold food varies and is not a specific time/meal of the day. From 12:12 p.m. to 12:30 p.m., trays were observed to be delivered from a food cart in the first floor dining room by CNA # 7. The door of	F 364	F-Tag F-364 Element #1 What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? It is the policy of this facility to see that each Resident receives and the facility provides food that is prepared by methods that conserve nutritive value, flavor and appearance; and food that is palatable, attractive, and at the proper temperature. Residents "K" and "H" currently are satisfied with the temp. of their food as served. Also, doors are closed in-between removal of food trays as they are being served. Adequate staff is available to serve trays. Element#2 How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? A facility wide audit of interviewable Residents was conducted to see if they had concerns with food temps as served. Any negative comments were documented and addressed. The Dietary Manager or designee will record food temps of food as it leaves the dietary department and also on the last tray served in the dining rooms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155298	A. BUILDING _____ B. WING _____	C 01/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 364	Continued From page 10 the food cart was left open from 12:12 p.m. to 12:30 p.m. while the trays were delivered to the residents. CNA # 7 was the only staff member present in the first floor dining room to assist residents during meal service. Interview with Resident # J on 1/11/11 at 1:35 p.m., indicated the food is sometimes not hot, though overall the food is OK. Interview with Resident # H on 1/11/11 at 2:50 p.m., indicated the food is sometimes cold. Resident # H further indicated the cart is brought into the dining room on the first floor and the trays remain in the cart until staff arrive from the second floor to serve the trays to residents. Interview with Cook # 5 on 1/11/11 at 12:32 p.m., indicated all food temperatures were over 170 degrees Fahrenheit prior to being served to residents. Steam was observed coming from the food remaining on the steam table. Interview with the Dietary Manager, on 1/11/11 at 12:33 p.m., indicated staff should keep the doors of the tray carts closed while trays are being delivered to residents to assist in maintaining the food temperatures once removed from the steam table. Review of the Resident Council minutes on 1/12/11 at 9:55 a.m., indicated dietary "concern forms" were presented to management for follow-up on 9/1/10 and 11/5/10. Interview with activity assistant # 8 on 1/12/11 at 10:10 a.m., indicated concern forms are filled out during Resident Council and forwarded to management staff for follow-up. The dietary concern forms were requested for review at this	F 364	This will be done on all meals 3 days weekly. Temps will be recorded. Any problems will be immediately addressed. Further, 10 interviewable Residents will be asked about food temps being satisfactory at least 3 days weekly on various shifts. Any concerns will be addressed. Adequate staff will be available to serve trays timely. The staff will be reminded to keep doors closed on the food carts between tray deliveries. This will be observed for at least 5 days weekly on various shifts to include all meals. All of this monitoring will continue until 4 consecutive weeks of zero negative findings is achieved. Then random weekly monitoring will occur. Note: Temps will be taken/recorded in dietary on all foods all meals on-going. Element #3 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? At an all staff in-service held 02/08/11, the importance of keeping the doors closed on the food cart between tray deliveries was reviewed. Any staff who fails to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate.	

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F 364	Continued From page 11 time. No dietary concern forms were brought for review prior to exit from the facility on 1/12/11 at 1:00 p.m.. This federal tag relates to complaint IN00084536. 3.1-21(a)(2)	F 364	Element #4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place 02/11/11 At the monthly Quality Assurance meeting the results of the food monitoring will be reviewed. Any concerns will have been addressed as discovered. Any patterns will be identified. If necessary an action plan will be written by the Administrator and the Quality Assurance nurse. This plan will be monitored by the Administrator until resolution is achieved.	